01616

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH: COUNTY Charles MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nanjemoy — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nanjemoy
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Annie	(Middle) J.	(Last) Adames	4. DATE OF DEATH	(Month) Feb.	(Day) 19	(Year) 1953
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept. 26 1870	9. AGE last birthday 82 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Selfe	11. BIRTHPLACE (State or foreign country) Charles, County, Md.	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME James L. Davis	14. MOTHER'S MAIDEN NAME ~~unknown~~ Sarah Holt						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT AND ADDRESS Kattie Willett Nanjemoy, Md.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442x Immediate cause (a)

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio-vascular-renal disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1920, 19....., to Feb. 18, 1953, that I last saw the deceased alive on Feb. 18, 1953 and that death occurred at 4 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George C. Bicknell	M.D.	Marbury Md	Feb. 19 1953

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE THEREOF 2-21-53	NAME OF CEMETERY OR CREMATORY St. John Nanjemoy	LOCATION (City, town, or county) ~~Clinton~~ Nanjemoy (State) Md
DATE REC'D BY LOCAL REG. 2-20-53	REGISTRAR'S SIGNATURE ~~M. L. Moore~~	24. FUNERAL DIRECTOR Nunett & Bros	ADDRESS Waldorf Md

Iola Thompson - cmc

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

COPY SENT TO LOCAL REGISTRAR No.____DATE____

RECEIVED
FEB 24 1953
BUREAU V. S.

01617

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY: Charles MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Grayton — LENGTH OF STAY (in this place): 10 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Grayton
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Amanda (Middle) L. (Last) Blackburn

4. DATE OF DEATH: (Month) Feb. (Day) 6 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug 27-1882

9. AGE last birthday: 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Alleghany County Old.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Levi Cartwright

14. MOTHER'S MAIDEN NAME: Mollie Piper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Levi C. Blackburn, Grayton Old

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
443x Immediate cause	(a) Cerebral Hemorrhage	3 yrs
Antecedent cause(s)	(b) Hypertensive Heart Disease	10 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1943, to 2/6, 1953 (1 x 40 PM), that I last saw the deceased alive on 2/4, 1953, and that death occurred at 12 40 P.M., from the causes and on the date stated above.

SIGNATURE: Frank Sesum M.D. (Degree or title) — ADDRESS: Indian Head. Old — DATE SIGNED: 2/6/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2/10/53 — NAME OF CEMETERY OR CREMATORY: Oedtown — LOCATION (City, town, or county): Oedtown (State): Md

DATE REC'D BY LOCAL REG.: 2/9/53 — REGISTRAR'S SIGNATURE: Julia H. Posey

24. FUNERAL DIRECTOR: Hunt & Ryan, Waldorf. Old — ADDRESS:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
FEB 11 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01618

101

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pisgah; LENGTH OF STAY (In this place) MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Charles; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pisgah; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Edward (Middle) (Last) Bowie

4. DATE OF DEATH: (Month) Feb (Day) 13 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)

8. DATE OF BIRTH: Apr 12 1889

9. AGE last birthday: 63 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Naval Powder Factory

11. BIRTHPLACE (State or foreign country): Charles Co. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John T. Bowie

14. MOTHER'S MAIDEN NAME: Susie Posey.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Benjamin O. Bowie.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cardiac Failure

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Hemmorhage.

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19 49, to Feb 13, 19 53, that I last saw the deceased alive on Feb 14, 19 53 and that death occurred at 9:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George E. Bichnell, M.D. ADDRESS Marlboro Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF Feb 16 53 | NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | LOCATION (City, town, or county) Mt. Lubland (State) Md

DATE REC'D BY LOCAL REG. 2-16-53 | REGISTRAR'S SIGNATURE H. L. Thomas

2-17-53 Mary Sutherland - cmc

24. FUNERAL DIRECTOR Hunter-Waldorf ADDRESS Md

VS. A15

COPY SENT TO ... DATE

RECEIVED
FEB 17 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0161?

Reg. Dist. No. 100

1. PLACE OF DEATH: COUNTY CHARLES — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HUGHESVILLE
LENGTH OF STAY (in this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY CHARLES
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HUGHESVILLE
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
SIDNEY	EDWARD	COATES JR.	FEBRUARY	2	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
MALE	NEGRO-U.S.	SINGLE	MAY 3, 1952		8	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	—	MARYLAND	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SIDNEY EDWARD COATES, SR.	ANNIE THERESA YOUNG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
NO —	NONE	ANNIE THERESA COATES HUGHESVILLE, MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
491X Immediate cause (a) ACUTE BRONCHIOLITIS	3 DAYS
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
— m.	—	—

22. I hereby certify that I attended the deceased from MAY 3, 1952 to FEB. 2, 1953, that I last saw the deceased alive on JANUARY 31, 1953, and that death occurred at 3 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
John N. Griffin, M.D.	Hughesville, Md.	Feb. 2, 1953.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	2-2-53	St Mary	Bryantown Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/2/53	Julia H Posey	[illegible]	[illegible]

2052201301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 6 1923
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01620

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: CHARLES — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: La Plata
LENGTH OF STAY (in this place): 24hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Charles.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Malcolm
STREET ADDRESS (If rural, give location): near Hughesville Chas. Co. Md.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Elwood (Last) COOPER

4. DATE OF DEATH: (Month) Feb (Day) 1 (Year) 1953.

5. SEX: M.

6. COLOR OR RACE: US-W

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify):

8. DATE OF BIRTH: 9 May 1950.

9. AGE last birthday: 2 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Ironsides, Chas. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Elwood Wilson COOPER.

14. MOTHER'S MAIDEN NAME: Deloris Irene Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Alice Edene Ginder. ~~Hartsville~~ Md. Malcolm

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
490X **Immediate cause**	(a) Respiratory failure -	24hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Meningitis	24hrs
	DUE TO (c) Left lobar pneumonia.	36hrs -

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 31 Jan., 1953., to 1 Feb., 1953., that I last saw the deceased alive on 1 Feb., 1953., and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE A. J. Woodby. (DEGREE OR TITLE) A.B., M.D. ADDRESS La Plata. Md. DATE SIGNED 1 Feb 53

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): DATE THEREOF 2/2/53 NAME OF CEMETERY OR CREMATORY Statesville LOCATION (City, town, or county) Statesville (State) Pa.

DATE REC'D BY LOCAL REG. 2/2/53 REGISTRAR'S SIGNATURE Julia H. Casey

24. FUNERAL DIRECTOR Hunt & Gow ADDRESS Waldorf Md

VS. A15 8-51

FEB 5 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1162

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Charles — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: La Plata
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: La Plata
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Celestia (Middle) R (Last) Garner

4. DATE OF DEATH: (Month) Feb. (Day) 17 (Year) 1953

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov. 3 1884

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Charles Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: George L. Garner

14. MOTHER'S MAIDEN NAME: Celestia G. Lyon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Rudolph Garner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
481X	Immediate cause	(a) Coronary occlusion.	15 min
	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Influenza.	1 wk.
		DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY: — M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 Feb., 1953, to 17 Feb., 1953, that I last saw the deceased alive on 17 Feb., 1953, and that death occurred at 12:15 A. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

A. L. Wood MD La Plata. 17 Feb 53.

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF 2/18/53 | NAME OF CEMETERY OR CREMATORY Mt. Rest | LOCATION (City, town, or county) La Plata (State) Md.

DATE REC'D BY LOCAL REG. 2/17/53 | REGISTRAR'S SIGNATURE Julia H. Posey

24. FUNERAL DIRECTOR Huntt & Ryon — ADDRESS Waldorf, Md.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0152

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head
STREET ADDRESS (If rural, give location) #1 Diffenbach

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) Wayne (Last) Goode
4. DATE OF DEATH: (Month) Feb. (Day) 16 (Year) 19 53
5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: Feb. 15, 1953
9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months Days 1 IF UNDER 24 HRS.: Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): La Plata, Md.
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Arthur Gorman Goode
14. MOTHER'S MAIDEN NAME: Hazel Charlotte Rison
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: Mr. Arthur G. Goode, #1, Diffenback, Indian Head Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

760.0

Immediate cause (a) Cerebral Hemorrhage
DUE TO
Antecedent cause(s) (b) Unknown
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/15, 1953, to 2/16, 1953, that I last saw the deceased alive on 2/16, 1953 and that death occurred at 2:15 P.m., from the causes and on the date stated above.

SIGNATURE Richard Daly, M.D. (DEGREE OR TITLE) ADDRESS La Plata, Md. DATE SIGNED 2/16/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 2/17/53
NAME OF CEMETERY OR CREMATORY St. Ignatius
LOCATION (City, town, or county) (State) Hilltop, Md.
DATE REC'D BY LOCAL REG. 2/16/53
REGISTRAR'S SIGNATURE Julia H. Pasey
24. FUNERAL DIRECTOR Hunt & Ryan, Waldorf, Md. ADDRESS

2023383407

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0162

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata, Md.
LENGTH OF STAY (in this place) 11 days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians' Memorial Hosp. La Plata, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE New York COUNTY Schenectady
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Scotia
STREET ADDRESS (If rural, give location) 209 N. Tenbroeck St.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Augusta Bertha Heitkamp
4. DATE OF DEATH: (Month) (Day) (Year) 2 19 1953

5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 1/1 1884
9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Schenectady, New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: August Dettbarn
14. MOTHER'S MAIDEN NAME: B Verwiebe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Albert Heitkamp 111 6th St. Scotia, N.Y.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
420.0 Immediate cause	(a) Congestive Heart Failure	10 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Myocardial Infarction complicated by embolism to lower aorta	10 days
	DUE TO (c) Hypertensive-arteriosclerotic heart disease	3 yrs.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/10, 1953, to 2/19, 1953, that I last saw the deceased alive on 2/19, 1953, and that death occurred at 11 P.m., from the causes and on the date stated above.

SIGNATURE Richard Daly (DEGREE OR TITLE) M.D. ADDRESS La Plata, Md. DATE SIGNED 2/19/53

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify): DATE THEREOF 2-23-53 NAME OF CEMETERY OR CREMATORY Park View LOCATION (City, town, or county) (State) Scotia N.Y.

DATE REC'D BY LOCAL REG. 2-20-53 REGISTRAR'S SIGNATURE M C Moore Jr.
24. FUNERAL DIRECTOR Hunt & Ryan Wall of Md ADDRESS

2-21-53 Julia H. Pasey

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 8-51

RECEIVED
FEB
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01624

Reg. Dist. No. 102

1. PLACE OF DEATH:
County: Charles
City or town: Doncaster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Doncaster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Noble E. Jackson

3. (b) Social Security Number

4. Sex: M
5. Color or race: C
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Rosie Jackson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years 77 | Months | Days | If less than one day ... hrs ... min.

9. Birthplace: Charles County, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm Owner

MOTHER
12. Name: Bailey Jackson
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden name: Lucretia Wallace
15. Birthplace: Charles Co. Md.

16. Informant: Noble Jackson
Address: Doncaster Md

17. Burial (Burial, cremation, or removal Which?) Date thereof: Feb. 7 1953 (month) (day) (year)
Cemetery or crematory: Mt Hope (Baptist)
Location: Mr Doncaster

18. Funeral director: Stanley Penny
Address: Mason Springs Md

19. Feb 6 1953 (Date rec'd by registrar) I V Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1953 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw him alive on Jan 30 1953

Immediate cause of death: Chr. Cardiac Disease

DURATION

Due to:
Due to: [illegible]

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Geo C. Bicknell M.D. M. D. or other
Address: Marbury, Md. Date signed: Feb 5 53

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route 224, near Marbury, Md.
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS NPF, Infirmary, Indian Head, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Florida COUNTY -----
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Tampa
STREET ADDRESS (If rural, give location) 3922 10th Ave.,

3. NAME OF DECEASED (Type or Print): (First) Crowley (Middle) Mason (Last) LIGHT

4. DATE OF DEATH: (Month) February (Day) 2 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 4, 1928

9. AGE last birthday: 24 yrs. If under 1 year: Months 5 Days 28 If under 24 hrs.: Hours ***** Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trucker

10b. KIND OF BUSINESS OR INDUSTRY: USMC

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Deceased--name unknown

14. MOTHER'S MAIDEN NAME: Nona LIGHT---Maiden name unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): March 26, 1952 to death

16. SOCIAL SECURITY NO.: _____

17. INFORMANT AND ADDRESS: None

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Injuries, multiple, extreme #8651	None
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) None	None
	(c) None	None

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None — None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Automobile

(CITY OR TOWN) (COUNTY) (STATE): Near Marbury, Charles, Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour): Feb. 2 1953 PMm.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Head crushed when auto overturned

22. I hereby certify that I attended the deceased from ******* 19** to ******* 19**, that I last saw the deceased alive on Jan. 30, 19 53, and that death occurred at approx. 10:20 PM on Feb. 2, 1953 m., from the causes and on the date stated above.

SIGNATURE: Geo. C. Buchanan (Degree or title) LT, MC, USNR ADDRESS NPF, Indian Head, Md. DATE SIGNED 2-3-53

GEO. C. BUCHANAN

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE: 2-3-53 — NAME OF CEMETERY OR CREMATORY: To U.S. Naval Hospital — LOCATION (City, town, or county) (State): Bethesda, Montgomery, Md.

DATE REC'D BY LOCAL REG. 2/3/53 — REGISTRAR'S SIGNATURE: Orby Price

24. FUNERAL DIRECTOR ADDRESS: U.S. Navy, Indian Head, Md.

Item 8 FilmG151 2/25/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18[illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pisgah Md
LENGTH OF STAY (in this place) 75 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Chas
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pisgah Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Fred (Middle) (None) (Last) Marburg
4. DATE OF DEATH: (Month) 2 (Day) 12 (Year) 53
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 8-5-18~~75~~77
9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pisgah Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Noble Marburg
14. MOTHER'S MAIDEN NAME: Celia Mack
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.: 220-16-4392
17. INFORMANT & ADDRESS: Mary Marburg - Wife Pisgah Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 450.0

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis Acute	3 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Arteriosclerosis	5 yrs
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Nephritis Chronic

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1, 1953 to 2-12, 1953 that I last saw the deceased alive on 2-12, 1953 and that death occurred at 11 a.m., from the causes and on the date stated above.

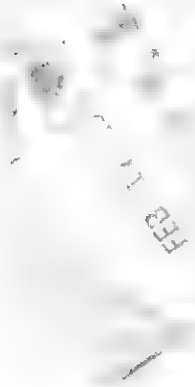
SIGNATURE [signature] (DEGREE OR TITLE) M.D. ADDRESS Indian Head Md DATE SIGNED 2-12-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 2-16-53
NAME OF CEMETERY OR CREMATORY Smiths Chapel
LOCATION (City, town, or county) Pisgah (State) Md
DATE REC'D BY LOCAL REG. 2-15-53
REGISTRAR'S SIGNATURE Mary Southerland
24. FUNERAL DIRECTOR Penny & Cafer ADDRESS Mason Spgs, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physicians Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pomfretville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Emma (Middle) P. (Last) Willard

4. DATE OF DEATH: (Month) Feb. (Day) 4 (Year) 19 53

5. SEX: F

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): M.

8. DATE OF BIRTH: Aug. 15, 1897

9. AGE last birthday: 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Chas. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank Middleton

14. MOTHER'S MAIDEN NAME: Adalaide Belle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Paul Millard, Pomfretville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 331X

Immediate cause (a) Cerebral Hemorrhage DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 2-2-53

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) DUE TO
(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-3, 19 53, to 2-4, 19 53, that I last saw the deceased alive on 2-4, 19 53, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE E. Medelen M.D. (DEGREE OR TITLE) ADDRESS La Plata Md. DATE SIGNED 2-5-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 2/7/53

NAME OF CEMETERY OR CREMATORY Holy Ghost

LOCATION (City, town, or county) (State) Issue, Md.

DATE REC'D BY LOCAL REG. 2/6/53

REGISTRAR'S SIGNATURE Julia H. Casey

24. FUNERAL DIRECTOR Hunt & Ryon, Waldorf, Md. ADDRESS

Item 9 FilmG151 2/25/53 whw

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ~~105~~ 100

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Physsicians Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) George Ward Oliver
4. DATE OF DEATH (Month) (Day) (Year) Feb. 8 1953 19
5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Mar. 17 1923
9. AGE last birthday ~~30~~ 29 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier
10b. KIND OF BUSINESS OR INDUSTRY U.S.Army
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Samuel G. Oliver
14. MOTHER'S MAIDEN NAME Mamie Shoemaker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) At time of Death
16. SOCIAL SECURITY NO. 216-16-0461
17. INFORMANT AND ADDRESS Samuel Oliver Father

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Basilar Skull Fracture

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Automobile accident

22. I hereby certify that I attended the deceased from 2/7, 1953, to 2/8, 1953, that I last saw the deceased alive on 2/8, 1953, and that death occurred at 1:23 a. m., from the causes and on the date stated above.

SIGNATURE Richard Daly (Degree or title) M. D. ADDRESS La Plata, Md. DATE SIGNED 2/8/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 2/12/53
NAME OF CEMETERY OR CREMATORY Arlington Nath ra
LOCATION (City, town, or county) (State) Arlington ra

DATE REC'D BY LOCAL REG. 2-12-53
REGISTRAR'S SIGNATURE M. L. Mourdie
24. FUNERAL DIRECTOR Hunt + Ryon ADDRESS Waldorf Md

2/13/53 Julia H. Pasey

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH: COUNTY Charles MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Victoria Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Victoria Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MOSES (Middle) SHANKS (Last)
4. DATE OF DEATH (Month) 2 (Day) 5 (Year) 1953

5. SEX M
6. COLOR OR RACE Negro
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 1867
9. AGE last birthday 85 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY U.S.

13. FATHER'S NAME George Shanks
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT AND ADDRESS Charles Co. Welfare Board La Plata Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) CORONARY THROMBOSIS

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH 4 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE Emil Spencer (Degree or title) J. M D ADDRESS Bel Alton DATE SIGNED Md.

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)
DATE THEREOF 2/7/53
NAME OF CEMETERY OR CREMATORY Shiloh
LOCATION (City, town, or county) Wayside (State) Md

DATE REC'D BY LOCAL REG. 2/9/53
REGISTRAR'S SIGNATURE William J. Rex
24. FUNERAL DIRECTOR Hunt & Rigon Waldorf ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 102

1. PLACE OF DEATH
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) (Last) Tolson

4. DATE OF DEATH: (Month) Feb. (Day) 8 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 17 1880

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Charles Co. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jessie Gibson

14. MOTHER'S MAIDEN NAME: Mary Gibson (?)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: James O. Tibbs.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 A

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George O. Bicknell M.D. ADDRESS Marburg Md. DATE SIGNED Feb. 8 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Buried

DATE THEREOF: Feb 10 1953

NAME OF CEMETERY OR CREMATORY: Oak Grove Baptist

LOCATION (City, town, or county) (State): Grayton Md.

DATE REC'D BY LOCAL REGISTRAR: Feb 8 1953

REGISTRAR'S SIGNATURE: Ellen Thompson

24. FUNERAL DIRECTOR: Stanley Penny Mason Springs Md

ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH 01631

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH: COUNTY Charles. ~~Chicamuxen~~ MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural (Rison) LENGTH OF STAY (in this place) 85 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural (Rison)
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Annie (Middle) (Last) Wheeler

4. DATE OF DEATH (Month) Feb. (Day) 11 (Year) 1953

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Sept 27 1867

9. AGE last birthday 85 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Rison. Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Albert Milstead

14. MOTHER'S MAIDEN NAME Alcinda Franklin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS George A. Wheeler, Rison. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443X Immediate cause (a) Cerebral Hemorrhage — 2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Heart Disease — 4 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1949, to 2/10, 1953, that I last saw the deceased alive on Feb 10, 1953, and that death occurred at 7:30 A m., from the causes and on the date stated above.

SIGNATURE Franklin Susan (Degree or title) M.D. ADDRESS Indian Head DATE SIGNED 2-11-53

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 2-13-53 NAME OF CEMETERY OR CREMATORY Chicamuxen Methodist Church LOCATION (City, town, or county) Chicamuxen (State) Md

DATE REC'D BY LOCAL REG. 2/13/53 REGISTRAR'S SIGNATURE ~~[illegible]~~ 2-16-53 Mary Southerland - cmc

24. FUNERAL DIRECTOR Hunt & Ryon ADDRESS Waldorf. Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

COPY SENT TO LOCAL BOARD ON _____ DATE

RECEIVED
FEB 16 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01632

CERTIFICATE OF DEATH

Reg. Dist. No. 100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Charles — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Malcom Twp — LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS En-route - Phys. Mem. Hospital La Plata

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Chas
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Malcom Twp Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Harry (Middle) Peter (Last) Wedding

4. DATE OF DEATH: (Month) 2 (Day) 1 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 2-28-90

9. AGE last birthday: 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm Laborer

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Peter Wedding

14. MOTHER'S MAIDEN NAME: Fannie Wedding

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Richard Wedding

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

480X

Immediate cause (a) Pneumonia w/ Bronchs — Interval Between Onset and Death: 3 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Influenza w/ — 3 days

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Primary Pernicious Anemia

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-16, 1953, to 2-1, 1953, that I last saw the deceased alive on 2-1, 1953, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

SIGNATURE James E. Andrews (DEGREE OR TITLE) ADDRESS Malcom Md DATE SIGNED 2-1-53

23. BURIAL, CREMATION / REMOVAL (Specify): — **DATE THEREOF** 2-4-53 — **NAME OF CEMETERY OR CREMATORY** St Charles — **LOCATION** (City, town, or county) Glymont (State) Md

DATE REC'D BY LOCAL REG. 2/2/53 — **REGISTRAR'S SIGNATURE** Julia H. Casey — **24. FUNERAL DIRECTOR** Smith & Son Waldorf Md — ADDRESS

VS. A15 8-51

RECEIVED
FEB 5 1953
BUREAU V. S.